Kansas
Department of Health and Environment
Division of Health Care Finance

STATE EMPLOYEE HEALTH PLAN (SEHP)
DEPENDENT GRANDCHILD AFFIDAVIT

Member and Grandchild Information		
Member's Name (LAST, FIRST, MI)	**Member's Employee ID or Social Security Number**	**Member's Phone Number** Including Area Code
Grandchild's Name (LAST, FIRST, MI)	**Grandchild's Social Security Number**	**Grandchild's Date of Birth**
Grandchild's Parent's Name (LAST, FIRST, MI)	**Grandchild's Parent's Date of Birth**	**Phone Number** Including Area Code

Is the grandchild's parent currently enrolled as a dependent under your SEHP coverage?	Yes ☐ No ☐
Is the grandchild's primary residence the same as your primary residence?	Yes ☐ No ☐
Do you provide more than half of the grandchild's support?	Yes ☐ No ☐
Do you have legal custody, or have you adopted your grandchild? **If yes**, date of legal custody or adoption: _____ **If yes, please include a copy of the first and last page of the legal custody or adoption document.**	Yes ☐ No ☐
Was the grandchild a U.S. citizen, a U.S. national, or a legal resident of the U.S., Canada or Mexico at some time during the tax year?	Yes ☐ No ☐

I hereby certify that the above listed information is true and correct. I agree that I will notify the SEHP of any changes in this information within 30 days of the change.

Member's Signature	**Date**

The member's signature must be notarized.

Subscribed and sworn to before me this _____ day of _____, 20____.

_____My commission expires _____, 20____.
Notary Public

(SEAL)